

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 1 6

2. STATE:

MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

07/01/01

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY _____ \$ _____

b. FFY _____ \$ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 3.1B, PAGE 8

ATTACHMENT 3.1A, PAGE 9

ATTACHMENT 2.2 A, PAGE 9b2,
PAGE 29b

PAGE 69, 69a, AND 70

SUPPLEMENT TO ATTACHMENT 3.1A, SERVICE 24d, PAGE 1-2

SUPPLEMENT TO ATTACHMENT 3.1B, SERVICE 24d, PAGE 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

ATTACHMENT 3.1B, PAGE 8

ATTACHMENT 3.1A, PAGE 9

ATTACHMENT 2.2 A, PAGE 9b2,
PAGE 29b

PAGE 69, 69a, AND 70

SUPPLEMENT TO ATTACHMT 3.1A, SERV 24d, PAGE 1-

10. SUBJECT OF AMENDMENT:

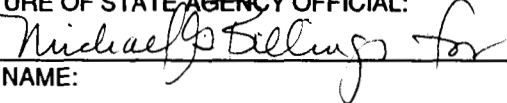
SUPPLEMENT TO ATTACHMT 3.1B, SERV 23d, PAGE 1

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

SINGLE STATE AGENCY DIRECTOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

GAIL GRAY

14. TITLE:

DIRECTOR

15. DATE SUBMITTED:

SEPTEMBER 13, 2001

16. RETURN TO:

DPHHS

GAIL GRAY, DIRECTOR

PO BOX 202951

HELENA, MT 59620-2951

ATTN: JEAN ROBERTSON

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

September 18, 2001

18. DATE APPROVED:

October 25, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Spencer K. Ericson

22. TITLE:

Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: September 17, 2001

Revision: HCFA-PM-97-3 (CMSO)
December 1997

MONTANACitation

1843(b) and 1905 (a)
of the Act and
42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

☒ All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); (b) receiving State supplements under title XVI; or (c) within a group listed at 42 CFR 431.625(d) (2).

☐ Individuals receiving title II or Railroad Retirement benefits.

☐ Medically needy individuals (FFP is not available for this group).

1902 (a) (30) and
1905 (a) of the Act

(2) Other Health Insurance

☒ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

MONTANA

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

- (1) 42 CFR 433.138 and 433.139.
- (2) 42 CFR 433.145 through 433.148.
- (3) 42 CFR 433.151 through 433.154.
- (4) Sections 1902(a)(25)(H) and (I) of the Act.

1902 (a) (25) (H) and (I)
of the Act.

42 CFR 433.138 (f)

(b) ATTACHMENT 4.22-A –

- (1) Specifies the frequency with which the data exchange required in § 433.138 (d) (1), (d) (3) and (d) (4) and the diagnosis and trauma code edits required in § 433.138(e) are conducted;

42 CFR 433.138 (g) (1) (ii)
and (2) (ii)

- (2) Describe the methods the agency uses for meeting the followup requirements contained in §433.138 (g) (1) (i) and (g) (2) (i);

42 CFR 433.138 (g) (3) (i)
and (iii)

- (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138 (d) (4) (ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138 (g) (4) (i)
through (iii)

- (4) Describes the methods the agency uses for following up on paid claims identified under §433.138 (e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party database and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

MONTANA

Citation

- 42 CFR 433.139(b) (3) ~~X~~ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
- (ii) (A)
- (d) ATTACHMENT 4.22-B specifies the following:
- 42 CFR 433.139 (b) (3) (ii) (C) (1) The method used in determining a provider's compliance with the third party billing requirements at § 433.139 (b) (3) (ii) (C).
- 422.CFR 433.139 (f) (2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
- 42 CFR 433.139 (f) (3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
- 42 CFR 477.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

MONTANA

Citation

4.22 (continued)

42 CFR 433.151 (a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

☒ State title IV-D agency. The requirements of 42 CFR 433.152 (b) are met.

☐ Other appropriate State agency(s) –

☐ Other appropriate agency(s) of another State –

☐ Courts and law enforcement officials.

1902 (a) (60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

☒ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

TN No. 01-016

Approved Date: 10/25/01

Effective Date: 7/01/01

Supersedes TN No. 92-09

MONTANA

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(e) of
The Act

28. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.
- ____ b. The State applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611 (e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

*Agency that determines eligibility for coverage.

TN No. 01-016

Supersedes TN No. 95-006

Approved Date: 10/25/01

Effective Date: 7/01/01

State/Territory: MONTANA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on attachment

TN No. 01-016
Supersedes
TN No. 92-03

Approval Date 10/25/01 Effective Date 7/01/01

MONTANA

The following limitations apply to Nursing Facility Services for Patients Under 21 Years of Age:

A. Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.
3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

B. Items or services that are not included in the payment benefit for services rendered by a nursing facility in the Montana Medicaid Program, but for which the resident may be charged are as follows:

1. Gifts purchased by residents;
2. Social events and entertainment outside the scope of the provider's activities program;
3. Cosmetics and grooming items and services in excess of those for which payment is made by Medicare or Medicaid;
4. Personal comfort items, including tobacco products and accessories, notions, novelties and confections;
5. Personal dry cleaning;
6. Beauty shop services;
7. Television, radio and private telephone rental;
8. Less-than-effective drugs (exclusive of stock items);

9. Vitamins, multi-vitamins, vitamin supplements and calcium supplements;
10. Personal reading materials;
11. Personal clothing;
12. Flowers and plants;
13. Privately hired nurses or aides;
14. Specially prepared or alternative food requested instead of food generally prepared by facility; and
15. The difference between the cost of items usually reimbursed under the per-diem rate and cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers).

State/Territory: MONTANA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.)

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

* Description provided on attachment

TN No. 01-016

Supersedes

TN No. 87(10)10

Approval Date 10/25/01 Effective Date 7/01/01

8. Less-than-effective drugs (exclusive of stock items);
9. Vitamins, multi-vitamins, vitamin supplements and calcium supplements;
10. Personal reading materials;
11. Personal clothing;
12. Flowers and plants;
13. Privately hired nurses or aides;
14. Specially prepared or alternative food requested instead of food generally prepared by facility; and
15. The difference between the cost of items usually reimbursed under the per-diem rate and cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers).